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## Conditionality in Context: Incapacity Benefit and Social Deprivation in Merthyr Tydfil

June 2006

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# Conditionality in Context: Incapacity Benefit and Social Deprivation in Merthyr Tydfil

## 1 Introduction

The aim of this report is to outline the issues surrounding conditionality and Incapacity Benefit (IB) within the context of Merthyr Tydfil in South Wales. Conditionality refers to a welfare contract where recipients of state benefits are obligated to undertake certain personal actions, such as taking part in rehabilitation programmes or return to work initiatives in the case of IB, and the receipt of benefits would be dependent on the claimant meeting the requirements set out in the contract. Merthyr Tydfil is an area where there is considerable social deprivation and corresponding high rates of poor health and IB claims. Needless to say, levels of poverty seen in the Merthyr Tydfil area urgently need to be addressed, and government policy reflects this in the high priority that is given to reducing economic inactivity and improving health in the South Wales Valleys. However, due to factors such as poverty, poor health and the limited employment opportunities seen in this context, conditionality may be less appropriate and more difficult to implement in an area like Merthyr Tydfil. Nonetheless, economic inactivity does need to be tackled in this area as part of the regeneration strategy to reduce poverty on an individual and community basis. The complexity of the relationship between health and worklessness in this region should not be underestimated, and it is best understood from a bio-psychosocial perspective. In this report, the benefits and difficulties associated with conditionality and IB claims are outlined, a socio-economic profile of the community in Merthyr Tydfil is provided, and the appropriateness of conditionality in this context is discussed.

## 2 Conditionality

### 2.1 *The welfare contract*

Empirically, *conditionality* is conveniently defined as the terms and conditions of a welfare contract: the individual person's responsibilities that must be accepted in return for social rights. Thus in the context of State Incapacity Benefits their receipt by people out of work because of a health-related problem might be conditional upon an obligation to undertake certain personal actions such as participation in a rehabilitation programme or a return to work initiative (Halpern *et al* 2004). Conditions attached to the receipt of social security benefits are the customary norm; the primary objective of which is to influence the behaviour of claimants and benefit recipients (Field 1997, Stanley *et al* 2004). On this basis the welfare contract is between a society that provides financial and other support to sick and disabled people who need it, and the recipients themselves who must meet certain obligations and responsibilities in return for that support.

## **2.2    *Citizenship and social rights***

The state may, indeed, legitimately demand and enforce these responsibilities and obligations as a condition for providing benefits. Does this welfare contract undermine citizenship? It is essential to maintain the legitimacy of sickness and disability benefits and the willingness of the taxpayer/voter to fund them. Mutual responsibilities and obligations are the bedrock upon which the ethic of solidarity supports social democracy. But this intrinsic moral attraction (Blair 1999, Goodin 2002) and perceived public support for this concept of mutual obligation (Williams *et al* 1999, Dwyer 2000, OECD 2003) must, among other matters described more fully below, be weighed against a compelling argument which advances welfare receipt as a human and social right of citizenship which should be unburdened and unconditional.

It has been emphasized (White 2004a, 2004b) that conditionality is contrary to liberal principles and it burdens those who are already unjustly disadvantaged. The imposition of special conditions on selected benefit recipients will depend much on the ways in which selection is made, and the perceived fairness of the criteria upon which it is based.

By contrast arguments have been advanced in favour of conditionality (Deacon 2004). These support the contractual agreement that social rights must be balanced by individual obligations and that there are mutual obligations between citizens irrespective of claims on the state. To a lesser extent there is also the paternalistic argument that conditionality is in the best interest of claimants themselves because participation is the main route to social inclusion and desirable integration. From the policy perspective, increasing participation is the key strategy to reducing social disadvantage, marginalisation and poverty.

Nonetheless, all authors who have written about conditionality, whether in its favour or not, conclude that conditionality can be philosophically and morally justified provided that very considerable care is taken to avoid burdening those people who are already unjustly disadvantaged. The nature and magnitude of multiple deprivation and disadvantage that exists among the population of Merthyr Tydfil, and indeed throughout the former coalfield areas of the South Wales Valleys and elsewhere in Great Britain, must be carefully considered in the context of the burden conditionality would place on people residing in these areas who exhibit gross evidence of multiple interactive foci of disadvantage, social exclusion and deprivation (Stanley *et al* 2004, Howard 2004).

## **2.3    *A new deal for welfare: Empowering people to work (2006)***

The Government's Green Paper "A New Deal for Welfare: Empowering People to Work", was published in January, 2006 (Department for Work and Pensions, 2006). That Green Paper observes that the current system for IB is now outmoded and based on factually inaccurate data of a large proportion of people who are currently in receipt, or claiming, IB. The proposed new

Employment Support Allowance (ESA) alongside the promised extension nationally of Pathways to Work (PTW) must focus on what people with disabilities can do in the workplace, rather than making assumptions about disabled people's limitations and restrictions to the detriment of the individual and, indeed, to society as a whole. It is very much hoped that in achieving its target of moving one million people off IB the Government's initiatives will not be solely concerned with new entrants to IB and fail to meet the needs and aspirations of those people in receipt of long-term IB. The Green Paper is unclear about this.

In the context of IB recipients, subject to multiple forms of disadvantage and deprivation found in the South Wales Valleys, the promised revision of the Personal Capability Assessment (PCA) - an important element of the gateway to IB - should take account fully of the range and diversity of the individual person's health problems within the context of the prevailing social circumstances. Revisions to the PCA must be carefully considered and crafted to allow for personal and social circumstances so that disabled people are not placed into training or employment which poses unacceptable burdens on other aspects of their lives or on activities with which they cannot cope. The social, domestic, and environmental milieu play a pivotal role in determining whether the disabled person is able to engage successfully in training initiatives and employment schemes. The application of "conditionality" must be sensitive to these issues, and the PCA designed in such a way as to identify and take appropriate account of the nature and magnitude of these circumstances which may limit an individual's successful progress through training and placement in employment. Rather than placing the emphasis on conditionality for continuing receipt of the ESA, the benefits of secure and worthwhile employment need particular emphasis. It is unsurprising that many people in receipt of IB in the longer term have acquired negative feelings about return to the workplace. The positive responses to the current PTW pilot schemes with their emphasis upon a greater understanding of personal and social circumstances, support and coping strategies, and financial incentives to return to work, are testament to the pressing need to acknowledge and appropriately address with understanding and sympathy negative experiences and lack of confidence which are potent barriers to return to the world of work.

#### ***2.4 Poor health, deprivation and the low skills trap***

The Chief Medical Officer for Wales has reported that the death rates in Merthyr Tydfil are almost 50 percent higher than in Ceredigion (Welsh Assembly Government, 2005) and commented that "there can be substantial differences within such areas as well as between them". Life expectancy at birth for males in Merthyr Tydfil is the lowest in Wales at 73.3 years compared with 78.5 years in Ceredigion - a difference of over 5 years. Among females in Merthyr Tydfil the life expectancy at birth is 78.1 years contrasting markedly with 81.9 years in Ceredigion (National Assembly for Wales, 2004).

The relationship between poor health and deprivation is well established and vividly demonstrated in children. Poor health in childhood is a valid predictor of continuing poor health in adulthood and multiple disadvantages ensue. Between 1998 and 2001, the infant mortality rate in the most deprived fifth of areas in Wales was 60 percent greater than in the most affluent fifth of areas (Kenway *et al*, 2005). It is evident that the “inverse care-law” (Tudor-Hart, 1971), that the availability of good medical care varies inversely with the needs of the population served, still applies.

In Merthyr Tydfil there exists a low skills trap (Finegold and Soskice, 1988; Rees and Stroud, 2004) which results in a substantial proportion of the socially excluded population effectively excluding themselves from the labour market. People receiving relatively high rates of State Benefits who have none or few qualifications cannot command a high enough wage to make work pay - even with the existing range of in-work benefit incentives (Cornwall, 2006).

The Welsh Assembly Government hopes to promote social mobility and to eradicate poverty (an income level below 60 percent of the UK median income). However, this aspiration will not be achieved if available jobs in the locality do not provide an income which exceeds 60 percent of the UK median (Cornwall, 2006).

Although the wide-range and diversity of New Deal and other labour market interventions provide a means for people to move into employment, many of these interventions may be adversely criticized in that they are focused on enabling the person to enter a job with only very limited work-focused training. The in-employment support is rarely robust and extensive, frequently the emphasis is mainly on administrative difficulties such as attendance, punctuality, and compliance with work routines.

It may be argued that these conventional labour market interventions do not engage with and address the challenges faced by those people in the population who are affected by multiple disadvantages, and are furthest displaced from the labour market. Whereas Education and Learning Wales (ELWa) funded programmes are principally concerned with work-based training and fail to address the low-skills trap. There are few, if any, incentives for employers to provide training and skills acquisition beyond those needed to discharge the job in-hand. Socially excluded elements of the population exhibit limited skills, work experience and qualifications, which place them well away from the labour market, leaving the great majority in the unenviable position of no effective support or encouragement to gain new skills and competencies.

Though sickness and disability lead to different rights and obligations they do not give exemption from the social contract or from personal responsibility (Duckworth 2001, OECD 2003). Equal citizenship does not necessarily mean treating everyone exactly the same; it may be reasonable to treat disabled people differently in order to achieve equal outcomes (Howard 2004). In this context one may advance the legal principle in

personal injury litigation, that claimants must “mitigate the loss”, i.e. do all that they can to recover from their injuries so as to minimize the need for compensation (Council of Europe 2002). Many benefit recipients agree that the imposition of conditions and therefore the exclusion of certain individuals from welfare rights can be legitimate, even though the extent to which they agree depends on the context (Dwyer 1998, 2002, Saunders 2002).

## ***2.5 Tests for conditionality policies***

White (2004b) suggested three philosophical tests of any conditionality policy:

1. The basic rationale: Does the policy have a clear rationale in terms of social democratic values?
2. The evidence test: Is there evidence that the policy is likely to produce the desired change in behaviour?
3. The unfair side-effects test: Is the policy fair?
  - (a) The inequity test: Does the conditionality rule generate objectionable inequity in the enforcement of social duties?
  - (b) The harm test: Does the conditionality rule generate unacceptable harm to society’s most disadvantaged group or groups?

It is notable that 59 percent of the British public surveyed in 2001 believed that “cutting welfare benefits would damage too many people’s lives” (British Social Attitudes Survey 2001).

Evidently any conditionality policy must also have a defined and immutable threshold at which the unambiguously clear behavioural sanction is applied. The sanction must also be targeted at the person who is non-compliant and not a third party (e.g. dependent children), and the person sanctioned must be capable of changing their behaviour (Collins and Rossiter 2004)

One of the central tenets of Howard (2004), who has expressed concerns about the unfairness of conditionality applied to disabled people in the benefits system, is that people should not be forced into activities they are unable to do because of their impairment or health condition. She emphasises that mandatory activity will not be effective unless appropriate, high quality support is readily accessible. Increasing pressure cannot make people (return to) work if the labour market does not provide suitable jobs. Conditionality can only be a fair process if there is real rather than a theoretical prospect of suitable work in which disabled people can engage. These concerns are of particular relevance to the population experiencing multiple disadvantages and a host of external barriers which one finds in Merthyr Tydfil and the South Wales Valleys. Mutual obligations must work both ways: the onus on society is to provide the opportunities, support and incentives before imposing conditionality on benefit recipients (Kuptsh & Zeitzer 2001, White 2003, 2004b, Deacon 2004, Howard 2004). This means that the nature of work-related responsibility (rather than exempting people from it) and the support required must be identified and met first.



Whilst there are reasonable grounds to suppose that conditionality can change behaviour, it is difficult for state agencies to enforce sanctions on behaviour or outcomes. It has been concluded that “heavy-handed use of benefit sanctions can be counterproductive” (Mead 1997). The real question is how to make sure conditionality and sanctions deliver the correct messages and influence behaviour to achieve this desired outcome?

It has been argued that conditionality is likely to meet with resounding political opposition, as evidenced by experiences in the Netherlands (Waddell, Aylward and Sawney, 2003). The Disability Rights Commission (DRC, 2003) argued that participation in work-focused activities should not be mandatory; but should be voluntary and based largely on claimants’ own perceptions of their health conditions and when they were ready for work. Voluntary participation and motivation have been central to the success of *Pathways to Work*; mandatory participation might undermine that success. The question must also be raised that participation in work-focused activities might be based more on the social model of disability, rather than the bio-medical model. In that context exemption from work-focused activities would be based on the nature and extent of the external barriers to work, and thus determined by socio-demographic, labour market and regional circumstances.

## ***2.6 Sanctions and disadvantaged people***

However, there is now concern that some people might be written off by not having Work Focused Interviews. It is certainly true that sanctions should feature as little as possible, and only as a last resort. In a sense this would be an admission that the process had failed. On the other hand any benefits process would be ineffective and meaningless without some form of ultimate sanction for unacceptable behaviour which goes beyond that which society as a whole would accept as reasonable compliance. But the central obligation upon those in receipt of IB is to (return to) work when the claimant is able to do so. There must, however, be safeguards to ensure that this obligation does not further disadvantage those who are already the most disadvantaged in society.

Conditionality, with inevitable discussion of rights and responsibilities, may lead to “help for those who help themselves”. That may be the most effective approach for those who are closest to the labour market; but it may fail the most disadvantaged and marginalised members of society. Among these are those people with health conditions or disabilities who are incapable of grasping the opportunity or who simply cannot meet the increasingly complex demands and obligations of participation in the contemporary labour market (Hattersley 1998). The evidence is lacking that stricter conditionality will be effective for these people (Gilbert 2000). The benefits system, and society as a whole, must make due allowance and provide the right sort of additional help and support for the deprived, the disadvantaged and the socially excluded (Hadler, 1996). Conditionality focuses on the rights and responsibilities of the individual. This must always

be balanced by the obligations and responsibilities of Government, Society, and the Benefits System itself. In this context there are also corresponding duties and responsibilities on employers. All of society should provide active support for sick, disabled, and disadvantaged people and dismantle the social barriers, to improve health and social outcomes. This is not just a matter of state benefits and costs: it is about improving health and eradicating health inequalities, and about citizenship, social justice, and fairness.

### **3 Merthyr Tydfil**

Merthyr Tydfil has attracted considerable attention from policy makers, researchers, and the media over recent years due to the high levels of claims for IB in the region. However, the rate of IB claims may predominantly be explained by the levels of social deprivation in Merthyr Tydfil, including the poor health status, lack of skills and education, poor labour market, and poverty that are found in the poorest areas in the UK. There may also be regional and cultural factors that exacerbate the difficulties with incapacity for work due to health conditions in this region. These need to be better understood if we are to find an effective solution to the high levels of economic inactivity seen in this area. It is essential that we consider the impact that introducing conditionality on IB would have in a region where there is already considerable poverty and multiple disadvantage, and whether conditionality is likely to be effective in this context.

The Well-being in Work (WiW) Report (Phillips *et al.* 2006) gathered together information about health and work in the Merthyr Tydfil area from a wide variety of sources including statistical databases and policy documents for the first time in a systematic manner, thereby providing a socio-economic profile of the community. An overview of the key issues highlighted in the WiW Report, and their relevance to the issue of conditionality and IB claims in Merthyr Tydfil are provided in this section to provide the context in considering the introduction of conditionality for claims for IB in this region.

#### ***3.1 A demographic overview***

The population of Merthyr Tydfil currently stands at 55,400 (a decline of nearly 8% since 1991), against an overall population for Wales of 2.94 million. The WiW Report (2006) describes Merthyr and its environs as 'an archipelago of islands', as the region is made up of a number of smaller communities, with variation in the demographic context between these communities. There is certainly a need to improve communications and transport links between these communities if they are to prosper.

The percentage of people aged 65 years and over is relatively high in Park, Town and Vaynor Wards compared to the rest of Merthyr and Wales. However, over 30% of the population is aged 19 years and under in Gurnos, compared with 22% in Park and 25% across Wales. The percentage of people

who are single (never married) ranges from 38% in Park to 49% in Gurnos, nearly double the 28% of singletons found across Wales. There has been a consistent upward trend in the number of births to women under 25 in Merthyr over the past few years, with 45% of births in 2003 being to younger women, compared to 31% in Wales.

The Joseph Rowntree Foundation Report (Kenway et al, 2005) ranked Merthyr as the most deprived community in Wales in terms of both child poverty and working-age poverty. In Gurnos, for example, 37% of the population are in employment while over 13% of the population have never worked. There is a consistently higher percentage of IB claimants in Merthyr than Wales, and there is a clear difference between Merthyr and Wales in relation to the duration of time which people have been receiving benefits. In two-thirds of the wards in Merthyr more than 25% of the population are in receipt of state benefits – the highest level of state dependence. There is growing pressure across Wales and in Merthyr Tydfil to reduce economic inactivity, but this challenge needs to be considered in the context of the community, particularly in relation to the health of the population in question and the labour market in the region.

### ***3.2 Community health profiles***

Half of the communities in Merthyr are in the 10% of most deprived areas in relation to health in Wales. This is also reflected in the SF-36 scores collected during the Welsh Health Survey (2003/04), where Merthyr had the lowest Physical Health score for any area in Wales and the second lowest Mental Health score (Figure 1).

There are nearly 30% more people in Merthyr suffering with long-term illness compared to Wales overall. Merthyr has a consistently higher than average rate of people reporting illness and health problems, and has the lowest Physical Health score for any area in Wales, as well as the second lowest Mental Health score. As displayed in Figure 2, disease prevalence in Merthyr is significantly higher than in Wales in hypertension and respiratory conditions but especially in mental health, arthritis, back pain and diabetes.

Figure 1: Welsh Health Survey SF-36 Scores across LA areas

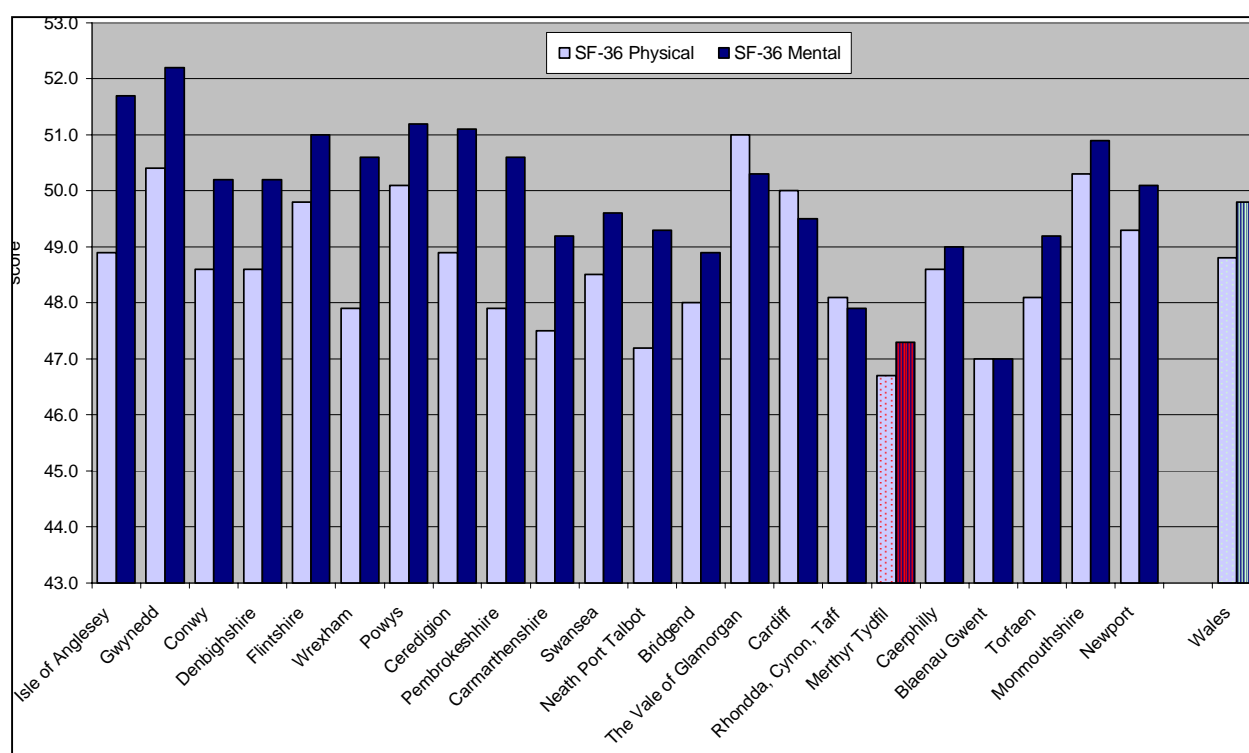
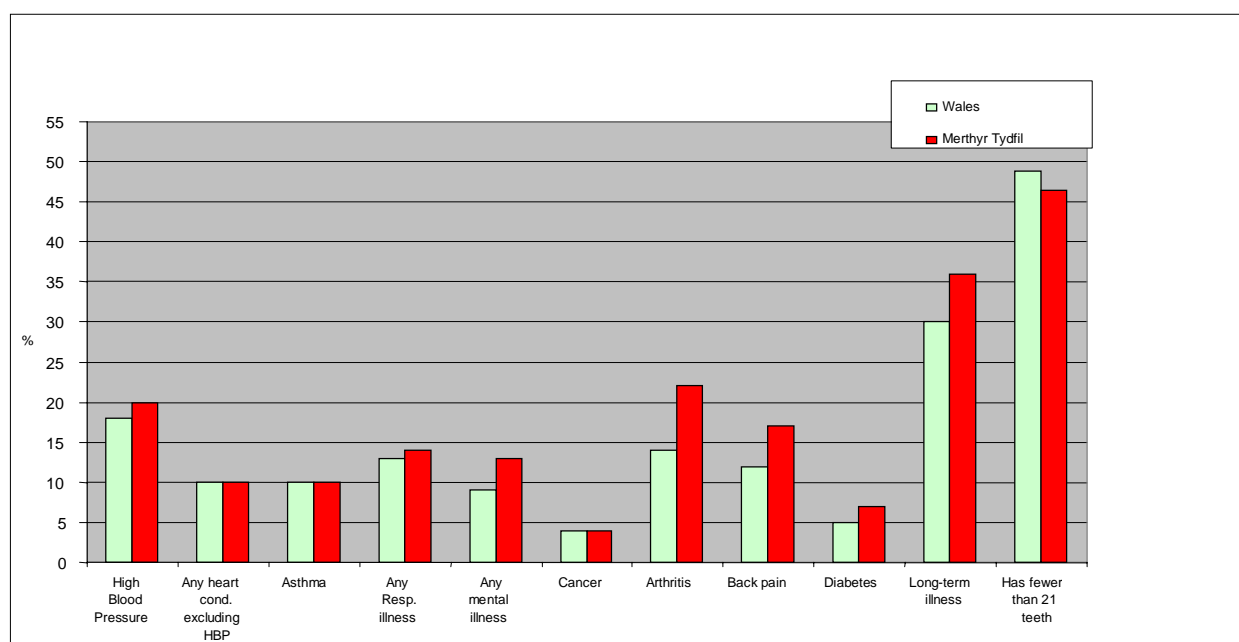


Figure 2: Percent of adults who reported key illnesses or health status

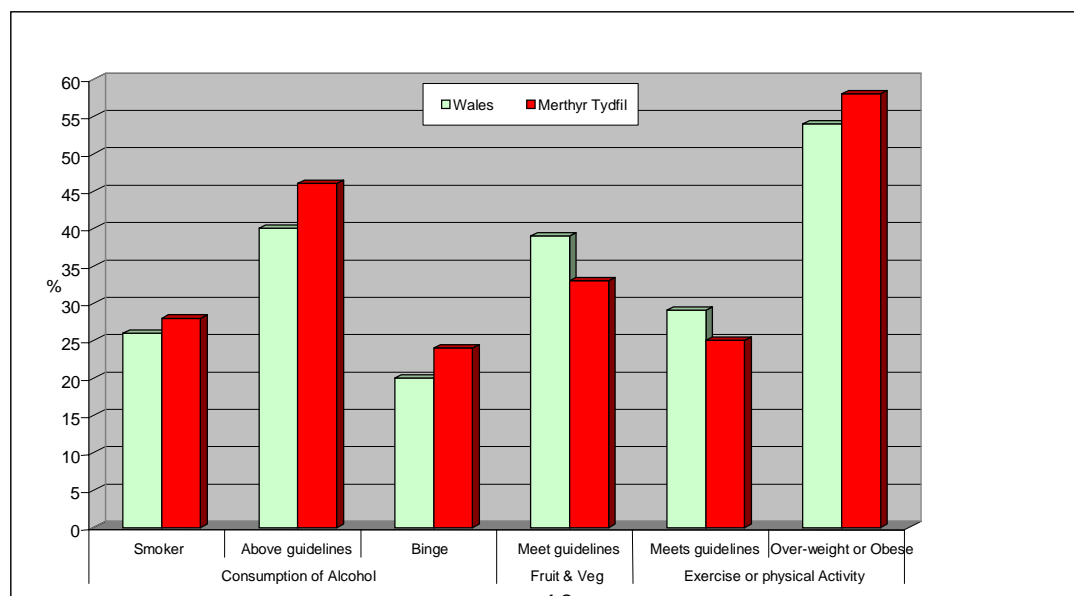


There were in excess of 1.2 million prescriptions provided in Merthyr during 2004-05 at a cost of £12 million - the highest rate per head of any LHB in Wales. However, the cost per item prescribed in Merthyr LHB is one of the lowest in Wales, and 20% lower than the highest cost LHB. People in Merthyr are more likely to visit their GP or practice nurse, are more likely to have

had a hospital out-patient appointment or attended A+E or been admitted as an in-patient, while they are less likely to have been a hospital day patient, or made contact with a pharmacist, dentist, optician or chiropodist relative to the rest of Wales. However, a greater percentage of out-patient appointments are not kept at North Glamorgan NHS Trust than in Wales, with particular problem areas being Palliative Medicine, Paediatrics, ENT, Dermatology, Obstetrics, Gynaecology and Psychotherapy. There are more people waiting for an initial out-patient appointment than the Welsh average, but fewer people than average waiting for in-patient admission and day-case treatment.

Merthyr has one of the highest percentages of low birth-weight babies in Wales (Kenway et al. 2005), while, along with Blaenau Gwent, it has the highest rate of teenage pregnancies in Wales. The Rowntree Report (Kenway et al, 2005) has illustrated the full complexity of the issues by reference to teenage pregnancies, where children born to teenage mothers are more likely to be of a low birth-weight, are more likely to die within the first few weeks of life, or develop certain chronic diseases, such as heart disease or diabetes, in adulthood. These children are more likely to perform poorly at school and have educational and emotional problems, and suffer illness, accident or injury. Girls born to teenage mothers are more likely to become teenage mothers themselves. Teenage pregnancy is a marker of the mother's present disadvantage, and therefore the disadvantage that the child is born into. It also relates to the future prospects of the mother, and can be an expression of low aspirations and lack of opportunity - the choice to have a baby may be considered a good option in the circumstances. The Report stated that around a third of the 50,000 children living in income poverty in Wales live in the Valley areas. In these areas the rate of child poverty is in excess of 30 per cent, with Merthyr ranked as the most deprived area in Wales. Furthermore, Merthyr has higher rates than the Welsh average for lifestyle risk factors for poor health, with higher rates of smoking and alcohol consumption above the recommended guidelines, and lower rates of exercise patterns and consumption of fresh fruit and vegetables (Figure 3).

Figure 3: Lifestyle behaviour

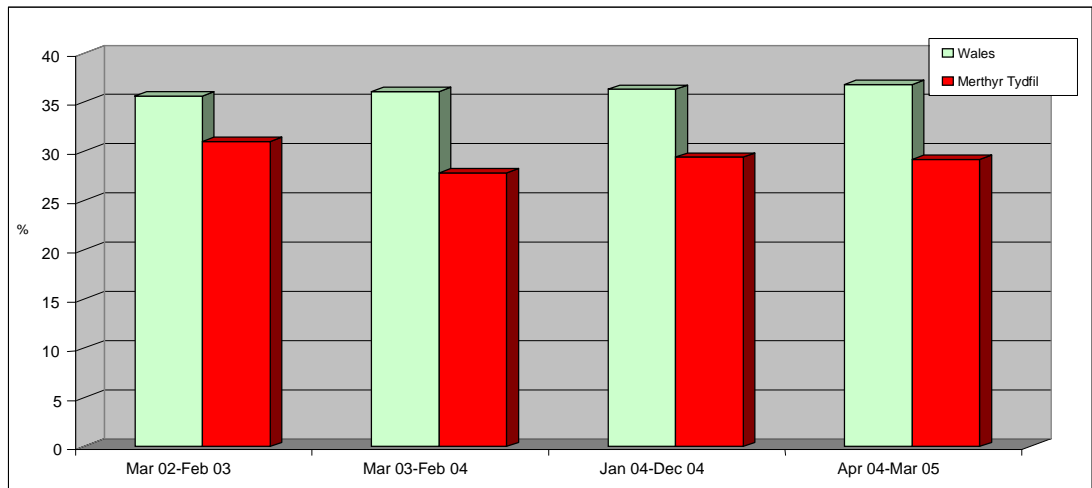


Unless these issues are addressed, they will store up further problems for this community in the future, and it is imperative that deprivation is tackled so that health in this community can improve.

**3.3 Employment and economic inactivity**

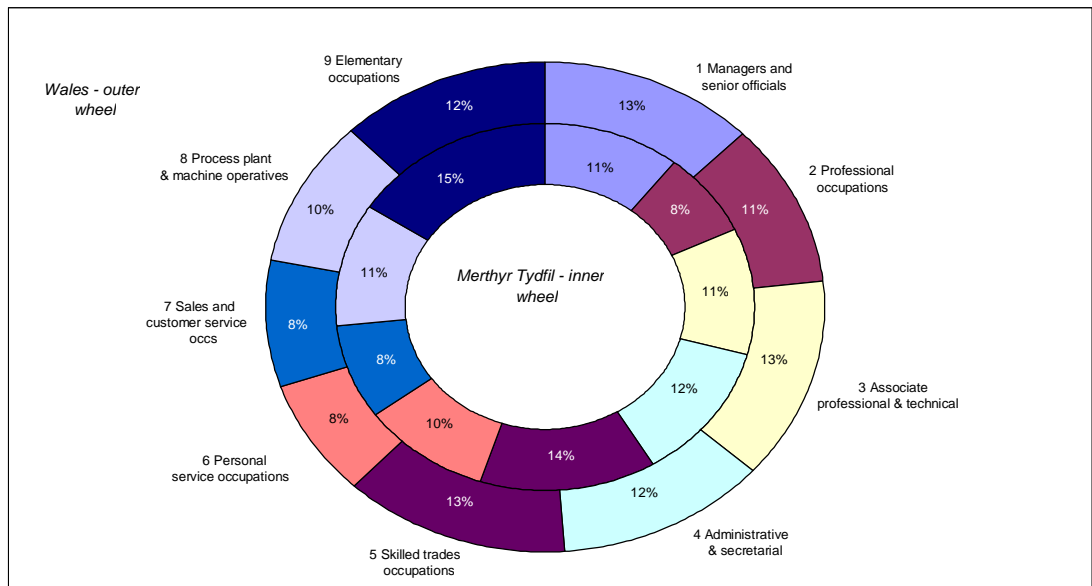
The percentage of the population in employment in Merthyr (28-31%) is consistently lower than in Wales as a whole (36-37%) and in Great Britain (40-42%), as shown in Figure 4.

Figure 4: Percent of population in employment (March 2001-05)



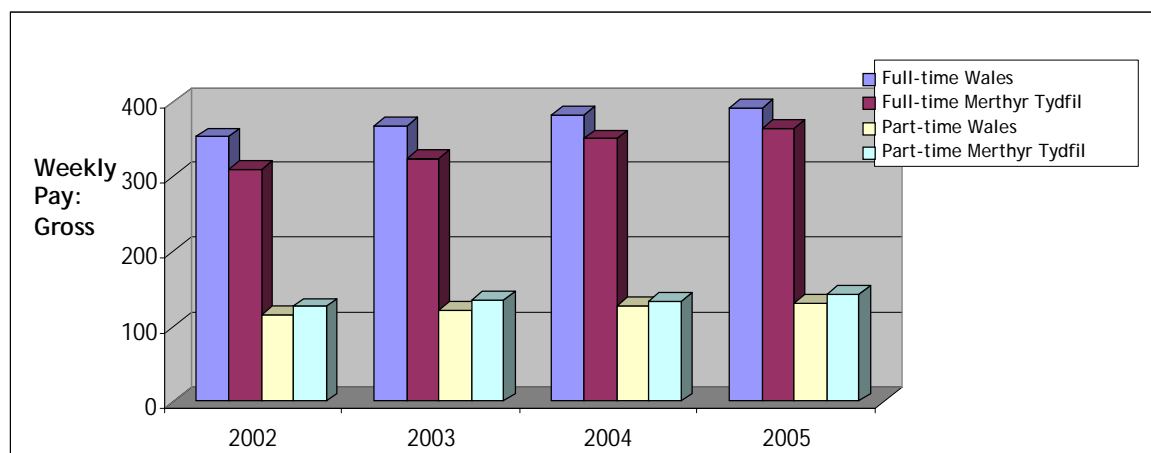
There are differences in the structure of employment between Wales and Merthyr (Figure 5). 19% of employees are in categories 1 and 2 in Merthyr compared to over 24% in Wales, and 28% in GB. In contrast 26% of people in Merthyr are employed in categories 8 and 9 compared with 22% in Wales and 19% in GB.

Figure 5: Socio-economic structure of employment



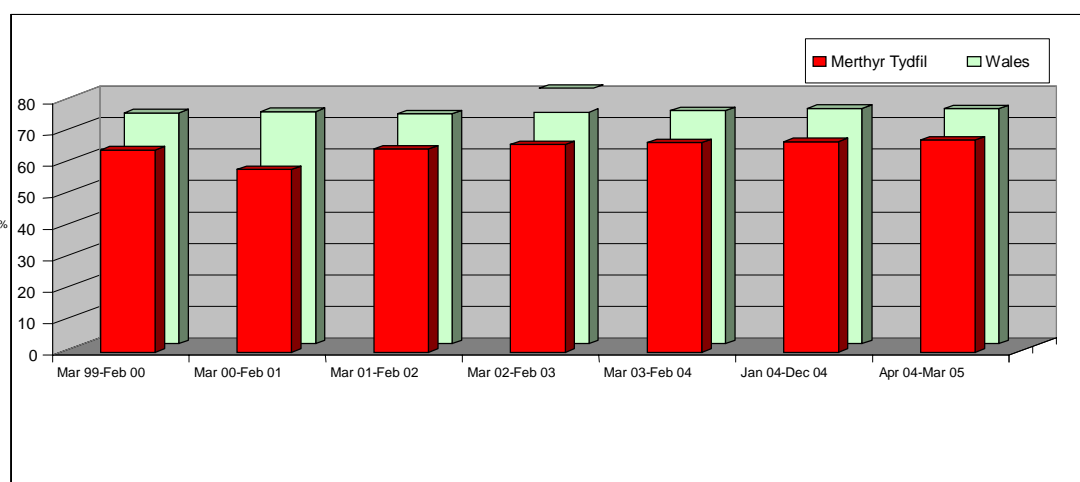
Gross weekly earnings are lower in Merthyr than Wales. However, there is a small difference in part-time earnings with Merthyr being slightly higher than for the Welsh average, as shown in Figure 6. There are signs that the differential in earnings overall may be closing, as annual gross earnings in Merthyr have increased from 85% of the Welsh figure in 2002 to nearly 89% in 2005.

Figure 6: Gross weekly earnings for Wales and Merthyr Tydfil



The percentage of those who have never worked is 7.9% in Merthyr compared to 5.6% in Wales, but there are wide variations across the Borough, with 13.5% of people in Gurnos never having worked. The unemployment rate in Merthyr is consistently higher than the Welsh average, and although not the highest in Wales, the proportion of people who are unemployed or economically inactive and who want work is running in excess of 12% of the working population. The percentage of unemployed who have been out of work for more than 15 years in Merthyr is 34%, and the percentage that have been out of work for more than 10 years is 54% compared to 30% and 48% respectively for Wales.

Figure 7: Economic activity rates in Merthyr Tydfil and Wales



While there has been pressure to increase economic activity rates across Wales, the rate in Merthyr (32%) continues to lag behind the Welsh average (25%) and those achieved across GB as a whole (22%). Therefore, taking all of the above indicators into account, it is not surprising that 36% of communities in Merthyr are in the 10% most deprived communities in relation to employment in Wales.

### 3.4 Social security benefits

The numbers on benefits (IB, JSA, and income related (IR) benefits) from 1999 to 2005 Merthyr Tydfil and Wales are shown in Figures 8 and 9. These figures illustrate that, despite a decline in numbers and percentages across the period, the differentials between Merthyr and all-Wales remain fairly constant, as evidenced in the decline in those on Job Seekers Allowance.

Figure 8: Benefit claimant groups (working age population) in Merthyr Tydfil from 1999-2005

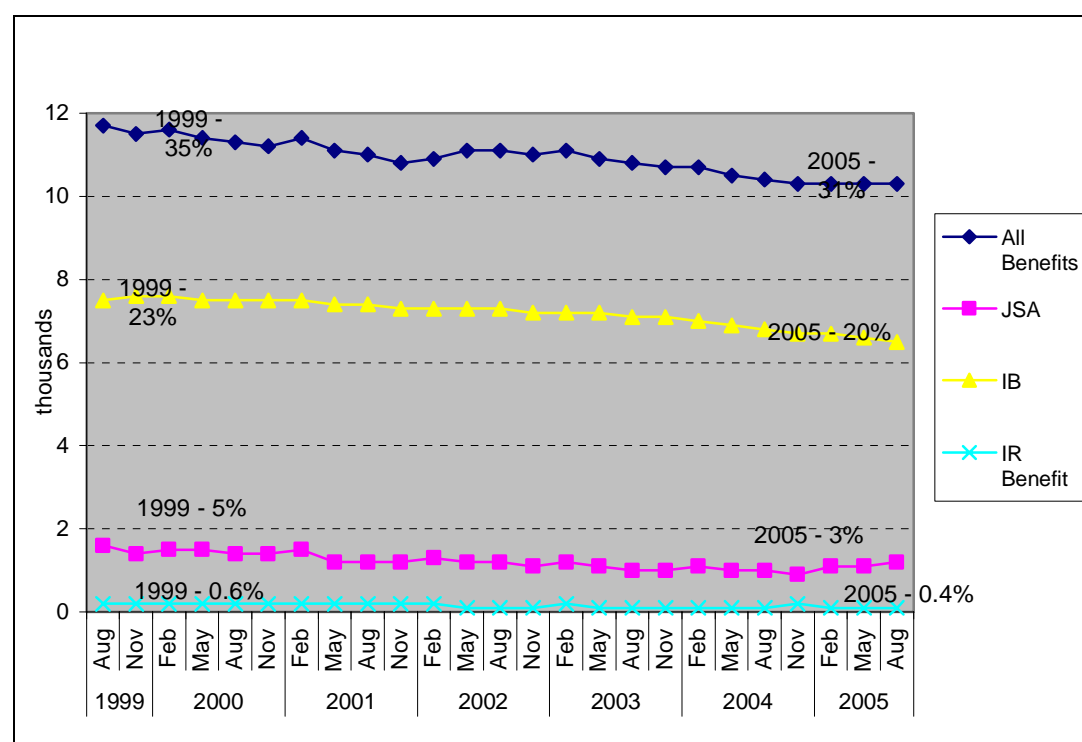
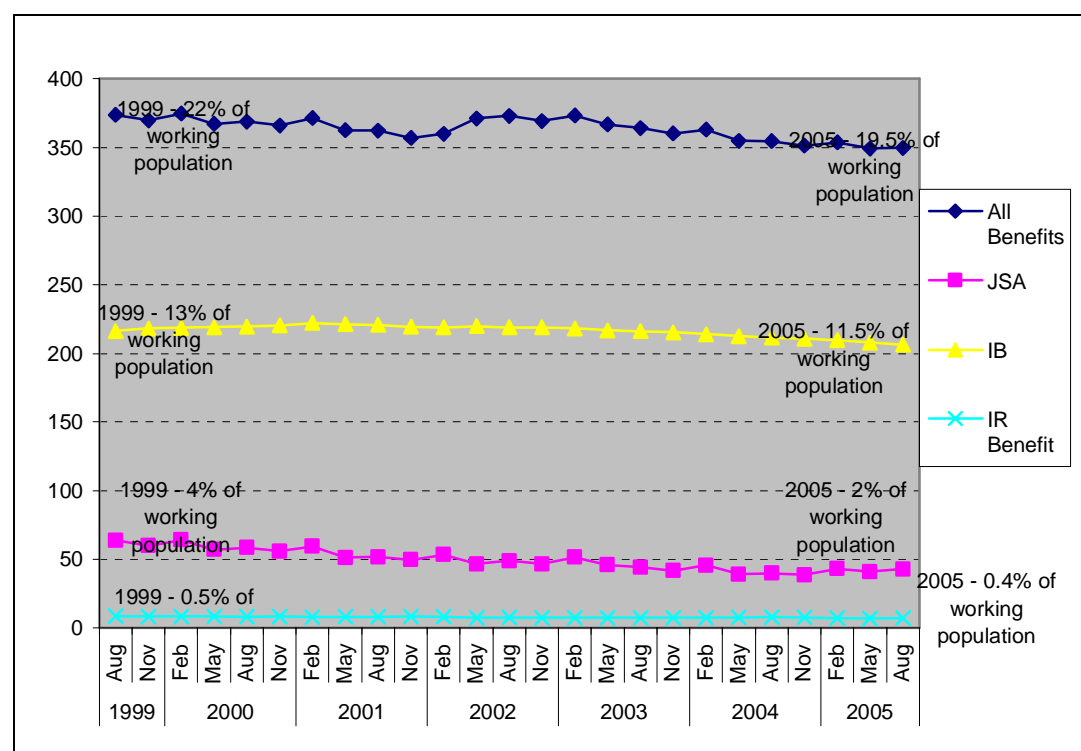




Figure 9: Benefit claimant groups in Wales from 1999-2005



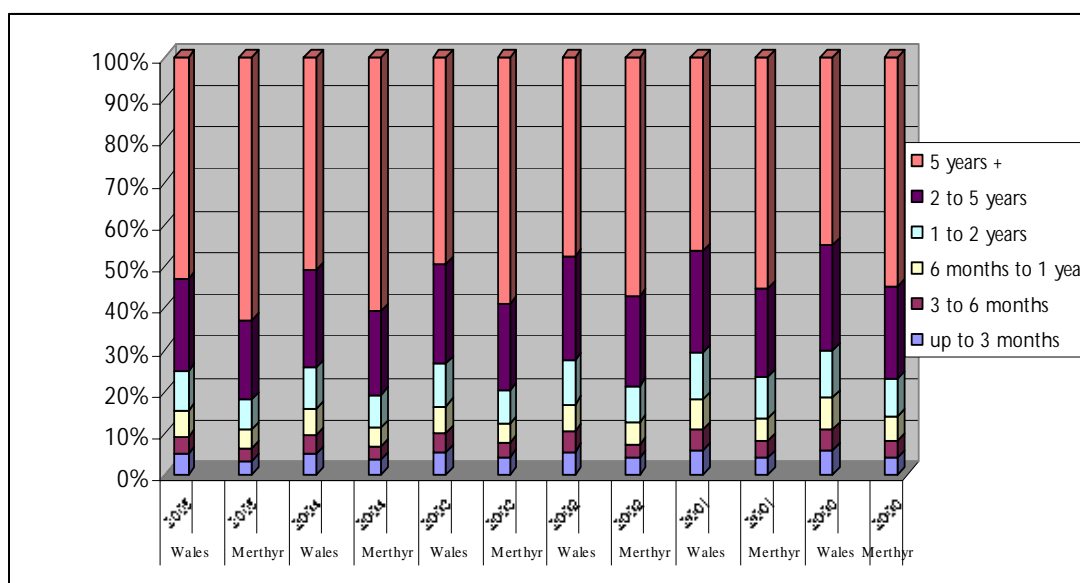
The proportion of IB claimants actually in receipt of benefit is also of interest. 'Claimants' include people in receipt of benefit and those who are not entitled to benefit (but keep submitting medical evidence) or who have had their benefit extinguished. Those who fail the contributions conditions receive a National Insurance Credit (denoted "Credits Only").

Table 1: Percentage of claimants receiving IB

		2005	2004	2003	2002	2001	2000
		%	%	%	%	%	%
In receipt of IB	Wales	69.1	69.8	70.9	71.8	72.6	73.5
In receipt of IB	Merthyr	73.5	74.1	75.0	76.4	77.2	78.5
Not in receipt	Wales	30.9	30.2	29.1	28.2	27.4	26.5
Not in receipt	Merthyr	26.5	25.9	25.0	23.6	22.8	21.5

There are a consistently higher percentage of IB claimants in Merthyr who receive IB than Wales - as shown in Table 1. This goes some way to validating the data relating to limiting long-standing illness. Furthermore, there is a clear difference between Merthyr and Wales in relation to the duration of time which people have been receiving benefits as shown in Figure 10.

Figure 10: Duration of benefits received



There is no specific data at the Merthyr level relating IB beneficiaries to specific diseases, and therefore the prevalence of conditions (ICD-10 codes) at the Welsh level has been used in relation to the number of IB beneficiaries in Merthyr. The total number of beneficiaries in Wales has fallen from nearly 150,000 in 2000 to 133,000 in 2005, but the number of beneficiaries due to mental and behavioural disorders has risen from 35,200 (24%) to over 40,000 (30%). On the other hand, there has been a decline in the number of beneficiaries suffering from musculoskeletal problems from 41,000 (28%) to 34,000 (26%). The figures are slightly different when claimants are considered, with mental and behavioural disorders accounting for 36% of claims in 2005 compared with 29% in 2000, and musculoskeletal problems falling from 25% in 2000 to 23% of claims in 2005.

There is a close correspondence between numbers of people on benefits and income levels within communities. For example, one measure of low income is the proportion of the population in each electoral ward receiving IB Severe Disablement Allowance or any of the main means-tested benefits, namely Income Support, Jobseeker's Allowance or the Pension Credit Guarantee. The proportion of people receiving state benefits exceeds 25 per cent in two-thirds of the wards in Merthyr Tydfil - the highest level of state dependence (Kenway et al. 2005).

Over the past few months there has been a decrease in the number of notified vacancies in Merthyr and surrounding areas. There would therefore appear not to be a great demand for employment within the region and it is necessary to carefully consider the approaches and schemes that can result in improvements in the economic activity rate bearing in mind that employment deprivation currently witnessed needs to be addressed.

### ***3.5 Poverty, social exclusion and deprivation***

The Rowntree Report (Kenway et al, 2005) stated that around a third of the 50,000 children living in income poverty in Wales live in the six Valley local authority areas of Neath Port Talbot, Merthyr Tydfil, Blaenau Gwent, Caerphilly, Rhondda Cynon Taff and Torfaen. In these areas the rate of child poverty - that is, the proportion of children who are living in income poverty - is in excess of 30 per cent, with Merthyr ranked as the most deprived area in Wales. The evidence to date highlights the extreme deprivation that exists within Merthyr in relation to employment and income.

The consequences of social exclusion and deprivation are often manifest in crime and drug and alcohol problems, and despite a fall in recent years, Merthyr still has one of the highest rates of reporting drug problems in Wales. Merthyr has the highest incidence of anti-social behaviour compared to the other areas within the South Wales Police Force region. The overall crime rate was 32.5 offences per 1000 of the population, compared with 24.7/1000 in Wales in 2003-04.

There are also clear linkages between levels of deprivation and educational attainment. 44% of the population in Merthyr have no qualifications compared to 33% of the Welsh population, with the percentage rising to 57% in Gurnos. Merthyr has 28% of its communities in the 10% most deprived communities in Wales in relation to education and the Rowntree Report (Kenway et al, 2005) placed Merthyr as the most deprived authority in Wales in relation to performance at GCSE level; the second most deprived area in terms of attainment at Key Stage II; and, the second most deprived in the proportion of 18 year-olds who go on to higher education.

In terms of reducing claims for IB in this area, a holistic approach is essential, with consideration given to the high levels of deprivation, poor health and lack of education and employment opportunities amongst a significant proportion of the population within the area. Furthermore, the psychological and social barriers to return to work need to be understood and tackled. The solution to the problems in this area is not to simply make access to benefits more difficult, or even to obtain an individual's commitment to attempt to return to work. The complex and impoverished context within which these claims are made has to be considered and the underlying causes for economic inactivity and perceived poor health need to be addressed.

### ***3.6 Welsh Assembly Government (WAG) policies and strategies***

This section of the report seeks to provide an overview of the policy context for health and incapacity for work, including relevant current UK and Welsh Assembly Government economic, health and social care, and health and work policies that will impact on Merthyr Tydfil. Once again, this information was collated for the WiW Report (2006), with key relevant points being highlighted in this section.

In Wales, there has been an attempt to span traditional policy areas and adopt an integrated approach, with the Welsh Assembly Government (WAG) providing policies and programmes to promote equality of opportunity, social inclusion and sustainable development, as detailed in the *Well Being in Wales* document. The aims this approach are to achieve a more prosperous and fair Wales; a Wales that is fit for the future. There are five strands that underpin the planned approach to improving well-being in Wales, which are:

- ensuring that all public policies and programmes, not just health policies, contribute in some way to improving people's health and well being
- creating social and physical environments that encourage and support well being
- developing people's personal skills and knowledge so that they can take greater responsibility for health and make informed choices for their health and their children's health
- strengthening communities as a critical factor in improving people's well being
- ensuring health services are effective, efficient and accessible to all, and have a stronger role in preventing illness and disease

WAG economic policies need to be viewed in the context of its strategic agenda set out in *Wales: A Better Country (2003)*. This acknowledges that economic development has to be part of a wider agenda encompassing social justice, environmental improvements, better health, language and learning, and community regeneration.

The WAG strategy for economic development has been described in the consultation document *Wales: A Vibrant Economy (2005)*, focusing on encouraging sustainable growth through helping more people into work, and helping to raise earnings for those in work by maximising the value created in the Welsh economy. In highlighting some of the successes in increasing employment levels, reducing unemployment and raising earnings, the document recognises that such gains have not been witnessed across all areas, and there remain geographical areas which need specific attention, including Merthyr Tydfil.

Above average levels of economic inactivity tend to be concentrated in areas where other social, educational and health problems have relatively high prevalence levels. The document emphasises the need for partnership working across public, private and voluntary sectors, for example, the development of a regeneration framework for the Heads of the Valleys area. Among the proposed strategic economic development themes, there are two key aspects which have particular relevance to reducing economic inactivity in Merthyr Tydfil, which are:

- supporting job creation and helping individuals to tackle barriers to labour market participation in the world of work

- investing to regenerate communities and stimulate economic growth across Wales.

In terms of developing strategies to reduce economic inactivity in the context of IB claims in Merthyr Tydfil, the methods used need to be carefully considered in light of the roles of other indices of deprivation, including lack of education and suitable employment opportunities that act as obstacles to (return to) work.

### ***3.7 Health and social care policy***

The provision of health services and the extent of resources required are of central importance in improving health. It is clear that the health status of the population in Merthyr Tydfil is poor relative to the rest of Wales and the UK, which contributes to the high number of IB claims. These are contentious political issues, and have been highly prominent in the relatively short history of WAG, and indeed for virtually all governments in the developed world. The performance of the NHS in Wales and the rest of the UK has been subjected to intense media scrutiny and academic debate. Improving the health of the population is a key part of reducing incapacity for work as a result of health conditions, and it is likely that this relationship is bi-directional, where reducing economic inactivity would reduce deprivation and thus contribute to improvement in health.

The *Wanless Report* (The Review of Health and Social Care in Wales, June 2003) clearly emphasised the need for action on a number of fronts to remedy system deficiencies and secure developments in the Welsh health service to ensure improvements in health outcomes for the population. WAG has committed itself to redressing the inequalities in health that exist within Wales, and in comparison to the rest of the UK.

Ambitious proposals for the development of health services in Wales over a ten year period were documented in the Assembly's NHS Plan (2001) - *Improving health in Wales - a plan for the NHS with its partners*. Another feature of health policies has been the focus on collaboration and co-operation across agencies through formal and informal alliances, highlighted by the comments of the First Minister and the Minister for Health and Social Services:

"The Plan is rooted in a set of partnerships. These involve public bodies planning, implementing and working on policies in a joined-up way."

[Foreword by First Minister]

".....improving the health of the nation poses challenges that no one organisation can meet. Strong partnerships between the NHS, local government, communities and the voluntary sector are at the heart of our new and inclusive approach to health."

[Foreword by Minister for Health and Social  
Services]

During recent years, a variety of innovative multi-agency projects have been developed in Wales, involving collaboration between statutory, voluntary, and independent providers. However, there is a need for wider dissemination of good practice and removal of other barriers to partnership working between health and social care agencies if appropriate patient/client-centred care is to be delivered.

The *Health and Well-being Strategy* demonstrated a commitment to increase the effectiveness, efficiency and financial management of health and social services. This highlighted the need for organisations to be more responsive to the needs of increasingly well-informed patients and clients, and ensure better access for those most in need, with a focus on 'whole-systems' thinking. It is envisaged that this will result in the provision of integrated health and economic policy initiatives, having long-term prospects of improving the 'health' of the Welsh economy.

The WAG *Designed for Life* (2005) document sets out WAG policy for creating a world-class health and social care service in a healthy, dynamic country by 2015. It draws on the objectives set out in 2001 in *Improving Health in Wales: A Plan for the NHS with its Partners*. It highlights the success of concentrating on delivering a healthy Wales through partnership, and goes on to detail the NHS Wales redesign challenge, philosophy and principles. It states that the service will be user oriented and based around a whole system approach, supported by targeted performance improvement, and that commissioning will be driven by clear and rigorous standards of clinical governance.

These services will look and feel very different to the public, and there is a clear emphasis on capitalising on technological advances, providing better access to information, encouraging individual responsibility for health and greater control over and choice of treatments. Home will be a health improvement setting and treatment centre using the home monitoring through telemedicine, and the latest technology will seek to ensure that hospital admissions are reduced, and return to home will be quicker. Action will be taken at several levels to keep people well and independent.

Health improvement will become a growing focus with its own policy and development, and will continue to foster efforts to target the causes of poor health. The NHS, local government and their partners will put their weight behind the effort to strengthen the approach to prevention at all levels. Individuals with health conditions will be helped to become 'expert patients' taking a high degree of control and responsibility over their treatment. Pre-planned care will be organised around the recipient's needs and convenience. There will be more information, a wider range of treatment options and greater certainty in the system.

WAG has also established Health Challenge Wales to act as the focal point of efforts to improve health and well-being, recognising that wide range of factors impact on health and well-being and that co-ordinated action can help to create a healthier nation. The scheme was launched in January 2005 and has been a noticeable feature of a number of initiatives carrying the Health Challenge Wales logo. It was set in the background of the report produced by the Chief Medical Officer Wales - *Health Status Wales 2004-05*, which highlighted the status of the health of the nation and the work that was required to improve it.

### **3.8 Work and health policies and strategies**

*'Securing health together: A long-term occupational strategy for England, Scotland and Wales'*, was published by the Health and Safety Executive in 2000. It highlighted three principal reasons for a long-term occupational strategy:

- to stop people from being made ill by work
- to help people who are ill return to work
- to improve work opportunities for people currently not in employment due to ill health or disability.

It sets itself three targets to achieve by 2010:

- a 20% reduction in the incidence of work-related ill health
- a 20% reduction in ill health to members of the public caused by work activity
- a 30% reduction in the number of work days lost due to work-related ill health.

It emphasised the need for concerted, concentrated, multi-factorial, multi-dimensional and multi-agency approaches to target collective efforts on the areas that need it most in achieving its targets. Once again, the role of partnership working was highlighted, involving Government, Local Authorities, individuals, large and small employers, trade unions and health professionals.

Major UK Government initiatives such as *Welfare to Work* agenda and the *Pathways to Work* programme developed by DWP, and were central to the aim of reducing the rates of workers moving on to, and remaining on, incapacity benefit. The success of the Pathways to Work Pilot schemes were instrumental in driving the welfare reform Green Paper, *A New Deal for Welfare: Empowering people to work* (DWP, 2006), launched in January 2006. The basic tenet of the Green Paper is to continue to break down the barriers that prevent people from fulfilling their potential and, through worklessness and economic inactivity, lead to poverty and disadvantage.

The Green Paper provides three specific targets:

- reduce by 1 million the number on incapacity benefits
- help 300,000 lone parents into work
- increase by 1 million the number of older workers.

There is an explicit commitment to reduce the number of people who leave the workplace due to illness, increase the number leaving benefits, and better address the needs of all those on benefits, with additional payments to the most severely disabled people.

The Heads of the Valleys Partnership Programme is one of the most important initiatives designed to tackle the issues faced by the Heads of the Valleys communities, including Merthyr Tydfil, launched by the Minister for Economic Development in November 2004. '*Heads - We Win...*' a strategic document for the Heads of the Valleys, 2005, set out the intention to develop an area with:

- strong, vibrant and well maintained town centres, linked by good quality public transport
- a full range of modern leisure, cultural and social facilities
- significantly improved health care (especially primary health care)
- better quality and more appropriate education and skills training for both children and adults (including access to high quality schools)
- the ready availability of a full range of housing types (including affordable and executive housing), especially within town centres

This programme should be underpinned by strong, clean and safe communities. The document highlighted that a strong, better balanced economy would offer significantly improved life chances, by helping to break down the structural barriers to work which exist in the area, and encourage engagement within wider Heads of the Valleys life.

There are several policies and initiatives in place which will impact on Merthyr Tydfil in Wales and the UK, which aim to improve health and reduce economic inactivity, and reduce the number of people who are unable to work due to a health condition. It is widely acknowledged that a 'joined-up' partnership approach is required to implement changes in the economy, health and social care provision, and health and work in Wales. The inequality in health seen in Merthyr Tydfil, along with other aspects of social deprivation, is high on the agenda for improving health in Wales, and there is a clear commitment to improving employment prospects and regeneration of the area. However, it is likely to be some time before these changes take effect in Merthyr Tydfil due to the extent of the problems seen in this community - it takes time to bring work in to an area and improve transport links, as well as educate and train potential employees, improve provision of health care, change health behaviour, and elicit cultural change.



In the mean time, a substantial proportion of the people living Merthyr Tydfil are living in deprivation, with high rates of poverty for both adults and children. If the way in which conditionality is applied adds to the burden for multiply disadvantaged people living in deprivation and social exclusion, then it would certainly be inappropriate in a community struggling to regenerate and improve. Providing an adequate level of benefit and support to raise people out of poverty, while focusing on the wider issue of regeneration of the area and tackling obstacles to return to work are likely to be more useful and effective approaches. There may well be a point in the future when the health of the disadvantaged population in Merthyr Tydfil, the economy, and employment prospects have improved, when conditionality could be more effectively applied in this area. Although significant progress is being made in Merthyr Tydfil to provide an increased number and variety of jobs in the community, there still exists a low-skills trap. This results in a substantial proportion of the socially excluded population effectively being excluded from the labour market. In this context, and taking account of the multiple deprivation that exists in a substantial proportion of this population, conditionality can only be morally justified if considerable care is taken to avoid further burdening people who are already unjustly disadvantaged.

#### **4 Placing conditionality in context: Reports from the community in Merthyr Tydfil and South Wales**

The links between illness, disease, and impairment, disability and work capacity are weak; these depend not only on underlying biological factors, but on psychological and socio-cultural interactions between the person and their environment. For common health conditions, personal factors are not simply secondary contextual influences, but rather an integral part of how the condition is perceived. Therefore, a biopsychosocial model is more appropriate for their understanding than the traditional medical model (Engel 1977, Waddell 2002).

Some three quarters of people of working age with long-term incapacity have mild to moderate common health complaints (CHCs), such as mental health, musculoskeletal and cardio-respiratory conditions (Aylward, 2004). There is often no clear or consistent pathological basis for CHCs, which are largely subjective in nature (Waddell & Burton 2004; Ursin 1997; Page & Wessely 2003). There is a surprisingly high prevalence of CHCs in the general population (Erikson et al. 1998, Kroenke 1993; Kroenke 2001)). However, whilst the prevalence of CHCs has been reviewed in specific medical settings and in the general population, little is known about the influence of perceptions, beliefs, attitudes, and behaviour and responses among people with CHCs. It is the subjective experience of these CHCs - and how they are interpreted - that drives people's actions (or in-actions). Understanding the high levels of IB claims in Merthyr Tydfil, and how economic inactivity due to health complaints could be tackled, requires a bio-psychosocial approach.

A study recently conducted at Cardiff University used focus group methodology to explore people's experiences of CHCs in the South Wales

area. This study explored a) what people think CHCs are, b) the psychological and socio-cultural factors that influence cognition and behaviour around common symptoms, and c) investigates the impact that CHCs have on people's lives, particularly in relation to work.

To investigate these subjective perceptions and experiences, qualitative methodology was used. A series of focus groups were conducted from November 2005 to investigate the main research questions. Focus groups can uncover the knowledge that a population have, and elicit shared attitudes, feelings, preferences and behaviours (Fern 2001). Gender, age and socioeconomic status are important factors found to interact with people's health beliefs (Charles & Walters 1998, Blaxter 1990/2004). Recruitment reflected these groupings, and they were for the most part kept separate, with homogeneity tending to elicit consensus opinions (as well as making people feel comfortable and encouraging interaction, Krueger & Casey 2000).

Recruitment took place in and around Cardiff and Merthyr Tydfil. Data was gathered from a community sample representing a range of views across the working age population in the South Wales. A researcher facilitated every group, which involved asking five main questions to elicit perceptions on CHCs. Group interaction was encouraged, and a co-facilitator summarised the main themes of the discussion to the group for validation purposes. The study included 2 focus groups that were conducted in Merthyr Tydfil with people who were receiving incapacity benefit, and included 2 men and 4 women. This is a small sample extracted from a wider study; people on IB in this area (and in general) are very hard to reach for research (and interventions). This difficulty in engaging IB recipients in research is likely to be due in part to trust issues. Nevertheless, the comments gathered in this study from these individuals are valuable in illustrating the structural, psychological, and sociological difficulties faced by people with a health condition living in this area face in returning to work.

The way that people talk about health and work is complex; individual, social, and structural explanations were used in the accounts, reflecting the complexity of how life and experiences are lived. In this section of the report, the focus is on the comments of people living in Merthyr Tydfil who are on IB in relation to the issues surrounding return to work and their experiences of claiming benefits.

#### ***4.1 Barriers to return to work: Psychological, sociological, and structural***

The discussions between individuals in Merthyr Tydfil receiving IB relating to barriers to return to work fell under three main categories: structural, psychological, and sociological barriers.

##### ***4.1.1 Structural***

As was highlighted in the WiW Phase 1 report, there are high levels of economic inactivity in Merthyr Tydfil relative to the rest of Wales and the

UK, along with high levels of claims for IB. However, this is influenced by the labour market in the area, among several other factors relevant to a disadvantaged and deprived population. This may have an impact on claims for IB, as difficulties in finding employment in general in the area will impact on those attempting to return to work after, or during an ongoing period of illness. The following comments highlight some of the issues surrounding the availability of jobs in Merthyr Tydfil:

*"...the mines and Hoovers were the two biggest employers in the area, and once they went there was no other industry coming really. Well, there's nothing really - the only thing that's come to Merthyr that's been really big is T Mobile, you know. There doesn't seem to be a lot of funds being put into the area to ... get people back into work"*

*"There's not really a lot of jobs around here anyway, unless you've got the qualification to back you up with it. There's factory work, and most of them ... you've got to sign up with an agency basically, so if your work isn't up to scratch within 6 months, well then you haven't got a job at the end of the six months anyway."*

(Eleanor 40)

*"Jobs are no good here - very menial very boring jobs. People prefer being on benefits than going on jobs"*

(Harry 30)

Not only does the availability of jobs appear to cause difficulties for those who are seeking work in this area, but the quality of the jobs that are available and lack of qualifications are also expressed as problems. Furthermore, the perceived low tolerance of agencies/employers of the kind of performance difficulties people may face when trying to work with a health condition and the effect of this on job security is also problematic. The lack of availability of suitable job opportunities can put considerable pressure on those who are in work as well as those who are seeking work, which makes it even more difficult for people with health conditions to secure and retain employment.

*"And I think the people who are in work - there's too much pressure on them too, because I, um, I know they do say 'well if you don't like the hours or if you don't like the way we doing something, well there's plenty more out there that will want the job', and they're threatening you with your job, and I think that is a pressure as well on people. As well as not being at work, you have the pressure of being in work."*

(Katie 39)

Skills and qualifications are also important in securing employment; the WiW report indicated that the average level of education of the population in Merthyr Tydfil was low relative to the rest of Wales. The need for

qualifications was recognised by the participants from Merthyr Tydfil in this study (see Eleanor's comments above). Leo (30) commented:

*"I did do a 3 week course. I was going to go into nursing, 'cos I was accepted to go into nursing as well, but, er, the problem is that there's not any money and I've got to get my finances right before I can be a student like. The last 4 years, I didn't have any qualifications, and I went to college and did 5 O'Levels. I done two A'Levels a HNC course in computing, and I just boosted the morale up, like. Small steps at a time..."*

Gaining qualifications can be very difficult for people living in areas high in social deprivation and low in skills, especially in light of financial concerns. However, in addition to the improved employment prospects on gaining qualifications, as Leo's comments highlight, education and training are also important in improving confidence and morale.

#### *4.1.2 Psychological*

People experience psychological barriers to return to work when they have been out of work due to illness. These can include the symptoms of mental health problems, the psychological problems associated with physical complaints (e.g. low mood and anxiety), or beliefs that act as barriers to return to work (e.g. lack of confidence in ability to function in the workplace, fear of facing stigma from colleagues/employers).

The symptoms of mental health problems can act as a significant barrier to return to work:

*"I had post natal [depression] twice with two of mine [children], but the other two were fine. I had anti-depressants and counselling, because I thought I was going mad, 'cos they were saying about putting me in hospital, and I kept saying "don't put me in a mental hospital" because I thought I'd lost it completely. They took like panic attacks, and it was like a year before they stopped, and like I still get low now... but I think having kids as well ... it knocks your confidence I think, the kids; it knocked mine."*

(Annie 42)

The symptoms this lady had experienced had clearly been the cause of considerable distress. Not only were the symptoms of her condition debilitating, but her confidence was also undermined by her experiences of post-natal depression. Confidence was a real problem for this individual, and was a considerable barrier to return to work, in terms of anxiety about ability to get work or attend an interview for a job, and to perform well at work:

*"I get it [sleeplessness] more when I'm low, like at the moment I'm OK. its just a confidence thing isn't it, I'm trying to get back into work and things..."*

*"Yes, I was suffering badly with gallstones, and I was just feeling so ill, and for me if I do a job I've got to do it properly and I've got to finish it, and I felt as if when I wasn't doing my job properly and I was letting everybody else down, and so I was feeling so rough anyway. I just gave up then, and then I've struggled to get back into work now with the confidence you know, the thought of going for an interview is like 'oooh'"*

*(Annie 42)*

The key question is how could individuals who have been through these experiences be enabled to return to work? The concepts of flexible working hours and graded re-entry to work are commendable, but in the current employment context of Merthyr Tydfil, it would be difficult to secure and retain a post with these conditions attached. Furthermore, the confidence of people who have been through these experiences needs to be rebuilt, and options such as training and education or voluntary work need to be made available to them to help improve their prospects of returning to paid employment and the financial, social and psychological benefits that it brings. However, careful consideration has to be given to the practicalities of this, particularly in terms of factors such as financial implications and childcare.

Despite the considerable difficulties faced by people with mental health problems, there is light at the end of the tunnel. With motivation and the right support, particularly to build confidence, people can improve their lives. Harry (30) had never worked, due to depression. He recalled:

*"I punched a wall through frustration. Frustrated; so I punched a wall and broke two of my knuckles... I've been on the sick ever since then, obviously felt down because I'm left handed so its definitely difficult looking after myself. Feeding myself - that was a bit difficult ... I've been on the sick since then. I've been on Want2Work, and it's been quite helpful, and see my life a bit better."*

Despite the difficulties Harry had faced with low mood and self-esteem, he was motivated to improve his life:

Harry:

*"[With depression, I've had] feelings of low self-esteem and low self-worth. It's been pretty tough, yeah..."*

Interviewer :

*"So what led you to start to do something about it?"*

Harry:

*"To try and get my life better, off the bottom, and hopefully get some employment and hopefully make my life... better"*

Katie (age 39) had also experienced depression, and had also taken part in the Want2Work scheme. She talked about her experiences of getting better, through starting small, getting an education, and building her confidence.

Interviewer:

*"How did you start to feel better [from depression]?"*

Katie:

*"I got out of the house put the babies in care in nursery; got out and I focused on other things, and I left school without any qualifications, and now I've got degrees and things and I lacked confidence. But its done so much for my confidence its unbelievable. I go to meetings, interviews and things and because we, I was saying this to you wasn't I, try a little course to start off with, something that your interested in."*

The issue of confidence and return to work were clearly of central importance to these participants, and the route to recovery involved re-building confidence through taking steps to gain skills and qualifications. Therefore, return to work needs to be encouraged through providing employment opportunities, support in developing skills and training, and building confidence. Imposing unreasonable conditions on receipt of benefits will not address these particular psychological barriers to work, but may well add to the anxiety and burden already faced by individuals on IB.

#### *4.1.3 Social*

In addition to the structural and psychological barriers to return to work, there are sociological issues that need to be addressed. These include factors relating to an individual's immediate social group (family and close friends), as well as to their community and their culture. Knowledge, attitudes and behaviour do not exist in a vacuum; they are socially contextual and socially constructed (Fern, 2001), and therefore social influences need to be considered in understanding barriers to return to work for IB claimants in the context of Merthyr Tydfil.

People living within a community will have commitments in their lives other than work, and in this context, working is not always easy or indeed possible. Amongst these commitments are caring duties - these are important, but can make working very difficult. Harry (aged 30) suffered from depression, and had been on IB since he had left school. He commented:

*"My father was, he...was my life - caring for him, and to die suddenly and, er... I'm having to rebuild from then rock bottom basically. It can be a pretty tough process..... Well, I've been off [work] since I left school... so since I left school I've been caring for my father"*

(Harry 30)

Not only was he living with depression, but he had also needed to care for his father. Furthermore, family commitments can prevent people from moving outside the area to seek employment when opportunities are not available locally:

*"I think a lot of the time as well, like you mentioned your father [to Eleanor], a lot of people won't go to different areas and things or move or emigrate because of family commitments."*

(Katie 39)

Furthermore, family is an important part of life; relationships with family members and events, such as losing a family member, can have a huge impact on an individual. The following extract of a discussion about mental health conditions in a focus group in Merthyr Tydfil illustrates the importance of family and life events in determining later employment opportunities:

Leo:

*"The biggest part of my life was [when] I was 13 - the most important part of your teens... and I think you can talk to your mother a lot better than you can talk to your father, and... Losing my mother at 13, then I just went inward rather than talk to my father about my problems... My father would always go down the club, and say "oh, he's OK, he's doing well, OK. He's doing this, and doing that". Well obviously not ... I wasn't really bright at school, but I was doing 10 O'Levels at school, and then I just left and wouldn't go back at 15 ... until I started education again about 4 years ago."*

Interviewer:

*"OK, and what about you..? [to Harry]"*

Harry:

*"... yeah, the same. My mother died when I was 14. My father didn't take it pretty well and didn't like it, more or less the same as that... left school with no qualifications, and lost my head a bit, and going back to it now - get my education to improve my prospects of gaining employment."*

Both Harry and Leo give examples of how the loss of their mothers had a great impact on them emotionally, and in terms of completing their education. The issue of incapacity for work is not a simple matter of functional impairment due to a specific set of symptoms: health interacts with life events, and a combination of factors can influence a person's ability to work, including their life experiences (and the impact these can have on educational attainment) and family commitments. In an area where there are higher levels of several key illnesses and early mortality relative to the rest of Wales, it is not just the current health status of the individual IB claimant that will determine whether they are able to return to work, as the health of their family, both past and present, could affect the opportunities for employment that are open to them in a very real way.

The way in which conditions are dealt with, both by health professionals and employers, could also have an impact on people's ability to return to work. Despite the fact that mental health conditions are perceived to be serious, real and high impact, there is still a stigma attached to them, and people don't always get the support they need. Harry (aged 30) said:

*"Oh, I don't think I had any help whatsoever from the doctor, whatsoever, 'cos if you go to the doctor with a stress-related illness he'll just say "well buck yourself up" or whatever. And just...he don't say it in fact, but I think he will say 'cos "I got more important things to deal with - better health patients"*

There are also adjustments that could be made in the workplace to support people with health conditions that would help them to remain at work when they become unwell:

Annie:

*"I think they could help deal with this problem if it was picked up early enough, and you know, if where your working are more - what's the word - if they're willing to sort of say "well yes, you've got depression we'll help you with that"..."*

Katie:

*"Take some of your workload off you and then it's more manageable"*

Annie:

*"And if they had the - yes, if you've got the help there and what have you, if you know what I mean. I mean even the counselling, if you're being counselled pretty quick... If you get there at the beginning of the depression rather than right near the bottom, then you're less likely to have depression that long. You know, it goes quicker. You might have a repeat of it, but you don't get it as often, like me - I don't get it as often as I used to."*

Early recognition of the problem, a supportive approach, adjustment to workload, and access to counselling services at an early stage were all thought to be helpful in removing barriers to staying at or returning to work. This is consistent with new thinking about mental health and work (Grove et al. 2005), and organisational factors such as workplace adjustments and support from employers, reducing stigma about mental health conditions, and early access to appropriate and effective healthcare services could help reduce economic inactivity due to illness.

#### **4.2 Experience and perception of claiming benefits (both self and others)**

As part of the issue of conditionality and IB in the context of Merthyr Tydfil, it is important to explore people's attitudes and experiences of claiming



benefits. The purpose of introducing conditionality is to encourage people to take steps to return to work. There is an underlying assumption that if conditionality is required to reduce IB claims, there is some lack of motivation to take steps to secure employment on the part of claimants that is contributing to the high rates of IB claims, which would be tackled by reducing the levels of benefit payment should they not take the agreed steps to return to work. Before making this assumption, we need to better understand people's attitudes towards claiming benefits in this region.

The experience and perception of claiming benefits in the participants from Merthyr Tydfil in this study were inextricably linked with Merthyr, particularly in the male accounts, and is still a part of the local discourse. Firstly, the reputation of Merthyr for having high rates of IB claims and crime were acknowledged by the groups, and that a proportion of people claiming IB did not want to work:

Irene:

*"Well, Merthyr I think is the highest town for people on long term sickness and incapacity benefit in the country isn't it. You know, it always was."*

Katie:

*"A lot of them don't want to work though."*

Irene:

*"That's true, it's just defining who wants to work and who doesn't."*

Katie:

*"They're getting more money not working."*

However, in understanding the lack of motivation to go to work referred to here, it is important to bear in mind the earlier comments relating to barriers to return to work: the availability and quality of employment opportunities, lack of education and skills, family commitments including caring for children and those who are unwell, and lack of adequate workplace adjustments. There are both real and perceived barriers to return to work for people with health complaints that need to be tackled to improve motivation, confidence, and ability to seek employment.

Where there is extensive social deprivation in a region, there can also be cultural barriers to returning to work and improving one's life. There are large numbers of people in the community living in poverty, and stress and depression are common problems. In this setting, it can be difficult to make a change, and there may well be feelings of resentment towards those whose situation improves, and frustration at being left behind. Leo and Harry discussed some of the difficulties people faced in trying to move forward with life:

Leo:

*".....So I think stress is the biggest problem within Merthyr borough like, through no work like, low self-esteem and everybody wants to be the same level. Nobody wants to see other people, er, go forward and, er, be successful."*

Interviewer:

*"Oh right - what makes you say that?"*

Leo:

*"Because if you see anybody in Merthyr that's done well, they're always put down like, so - everybody wants to be on the same income like, the same level... That's my opinion about Merthyr."*

Interviewer [to other participant]:

*"What do you think?"*

Harry:

*"Yeah, probably give the same as... I'd probably agree with what he was saying. Yeah, most stress and depression, most of the people on incapacity benefit are on with stress-related illnesses like me, myself."*

In truth, the levels of social deprivation in this region need urgent attention if these cultural issues are to be addressed. There is little wonder that people feel angry and frustrated when they are living in poor conditions and have little prospect of improving their situation, and yet this likely to act as a cultural barrier to improving health and wealth of people who wish to do so. Harry and Leo also discussed their views about the high levels of IB claims in the area:

Harry:

*"The reputation is of Merthyr having 20% on IB and being quite violent."*

Interviewer:

*"How do you feel about that?"*

Leo:

*"I think it's right, really."*

Harry:

*"I agree, there's no smoke without fire."*

Leo:

*"Merthyr is given scraps from the government to get by, and if they're [people on IB] not causing trouble they're left alone. Think that's why they give IB to keep them happy, because we're [Merthyr] not getting aid for jobs. MPs won't speak up against benefits because*

*they know they're not getting aid for jobs...if they did people would leave Merthyr."*

This exchange highlighted how the statistics in the WiW report are reflected in people's discourse. Merthyr Tydfil has acquired a bad reputation through the media and, unfortunately, this may also have been exacerbated by campaigns founded on good intentions to highlight the social deprivation in the area. There was a feeling of having been let down by the government, who were seen to be giving them scraps to live on rather than providing jobs. Again, these comments emphasise that it may not be conditions on benefits that are required in this context, but rather education and training, employment opportunities and good healthcare...

Furthermore, the perception that people are claiming benefits because they 'prefer' it in some way to work needs to be challenged. People's experiences of claiming benefits in this study were negative on the whole, particularly in terms of all the forms that need to be completed, and delays in receiving benefits:

Eleanor:

*"It was all a nightmare, some of the forms are like - oh God!"*

Katie:

*"Well, they signed me off since November with 'incapacity' ... they break you in slowly if you're incapacity to try and go back into work. And how many forms have I sent in? Six."*

Eleanor:

*"Yes, about that."*

Katie:

*"And they never received any of them so I haven't had no money from anywhere since November, so I've been living off my husband's wage, which is really hard with three kids, so I think I've got all that now."*

Eleanor and Katie discussed this further, talking about the personal questions that were asked, particularly about finances:

Eleanor:

*"Well it's a long time when I was off work on the sick with my back problems, um, the forms that I had to fill in were unbelievable. There were pages and pages and pages. Um, some information they didn't really need to know 'cos it was my first month"*

Katie:

*"Um, yes they ask a lot ... don't they"*

Eleanor:

*"A lot of personal questions"*

Interviewer:

*"What sort of, well - you don't have to tell me if you don't want to but..."*

Katie:

*"Same as bank accounts and things"*

Eleanor:

*"Have you got any savings, how much have you got, you know - things like that - which they don't really need to know, you know so, but it's a good few years when I was on the sick. Um, I had to fight the doctor mind to send me for x-rays to have z-rays done, um, for a good few weeks, so. But I haven't been on the sick for a good while now."*

In fact, one lady, Alice, had avoided claiming IB altogether on account of the claims procedure, despite having clinical depression:

Annie:

*"I'm not claiming nothing (anything), my husband says I should be claiming dole because I'm entitled to it."*

Interviewer:

*"How do you manage?"*

Annie:

*"Oh, I can't be doing with these forms. I did go - I'm worried in case I fill them in wrong and I get into trouble, but I did go into the dole because he's (husband) been nagging me, and I said 'oh, I'll do it Tuesday'. So I went down the dole, and I looked for the jobs down there in it, but I couldn't bring myself to sign on. I just walked back out."*

Katie:

*"But then the only thing is by not claiming nothing (anything), your stamp isn't being paid, that's the only thing"*

Annie:

*"They [Want2Work] said, you know, 'cos I should have claimed when I went off on the sick - to me see, I'm not sick"*

ALL:

*"Yes, you are..."*

Annie:

*"It's a confidence thing with me at the minute - its not depression. I'm not sick, so I can't claim sick, so I don't claim anything because I'm not. To me, I shouldn't be claiming anything because I'm not ill, if you know what I mean"*

The financial hardship experienced by people on state benefits was illustrated by these comments from Harry:

Interviewer:

*"How do you manage on benefits?"*

Harry:

*"I've no car, it's hard. It's tight paying bills, and saving for clothes."*

These were not people living in wealth on state benefits, as has been portrayed in the media in some cases over recent years. There is considerable poverty both in children and adults in the area, and health status is poor relative to the rest of Wales, as highlighted in the WiW Report. The comments from people in the focus groups reflect their personal experiences of incapacity for work and the multiple disadvantages they have experienced, suggesting that they face a variety of obstacles to return to work, and are in genuine need of financial support. It would be naïve not to acknowledge that some individuals within the region and across the UK make fraudulent claims. However, these people are in the minority, and the vast majority of people claiming state benefits in this area are multiply disadvantaged and in need of support.

These findings highlight the complexity of the issues surrounding health and work faced by people on IB in Merthyr Tydfil. These are the experiences of a small number of participants, and further research is required to explore the nature and extent of the structural, social, and psychological obstacles to return to work for people on IB in Merthyr Tydfil. Further research is being conducted at the UnumProvident Centre for Psychosocial and Disability Research at Cardiff University in this area to find out more about psychosocial aspects of CHCs. The WiW Partnership programme of research will be investigating the relationship between health and work, and will scope current provision and need for work retention/rehabilitation interventions in Merthyr Tydfil. However, the evidence gathered so far in the WiW Phase 1 Report and the accounts of personal experiences gathered during the focus groups suggest that many people in this region are living in real poverty, with genuine health problems, and face practical, structural, psychological, and social barriers to returning to work. In this context, it is important to ensure that conditionality is not applied in an inappropriate way, which may add to burden of individuals unable to work due to their health, without solving the underlying problems.

## 5 Conclusions

Introducing conditionality on IB claims in the context on Merthyr Tydfil is likely to have a negative impact on the people claiming this benefit, by imposing a further burden on who are people already living in deprived circumstances, who are unwell, have insufficient education and training, and are living in an area where there are few job opportunities.

Getting people back to work is very important, and will be crucial in the regeneration of the area, as it can help lift the communities within Merthyr Tydfil out of deprivation. The DWP Want2Work and Pathways to Work initiatives have been successful in this area so far, but more needs to be done. The reality for an individual with a life limiting health condition compromised by other disadvantages being able to get work under present conditions in Merthyr Tydfil is remote.

Many factors influence whether or not a health condition leads to incapacity for work. Most certainly, a person's perceived state of health and well-being comes high on the list. However, work incapacity depends on interactions between health-related, psychological, and social factors. Moreover, recognition of the complex factors influencing incapacity for work must not disregard the individual's free will and personal responsibility for one's actions. The less severe and more subjective the health condition, the more important the role of personal factors (e.g. motivation, effort, attitudes, beliefs, behaviours and participation).

There are close links between poor health, disability, unemployment and poverty. The social and regional disadvantages which affect a significant proportion of the population in Merthyr Tydfil are critically important in the consideration of the role of conditionality as an effective tool in moving people to (or return to) work. As demonstrated in this report, many IB recipients in Merthyr Tydfil, as in other deprived areas of the country, have multiple disadvantages, and face multiple barriers to work: age, work history, low skills, local labour market, high unemployment rates and attitudes of health professionals and employers. Even were a health condition not totally incapacitating, it is profoundly confounded by these other disadvantages. The threshold for receipt of IB depends on whether sickness or disability makes it unreasonable to expect claimants to attempt or make efforts to (return to) work. With many common health problems, this is ultimately a social matter rather than a medical judgement. It may be argued within the context of state benefits that conditionality, which imposes an obligation for an individual to undertake certain personal actions in return for a certain level of financial support, can only be philosophically and morally justified if very considerable care is taken to avoid burdening people who are already disadvantaged. Moreover, conditionality can only be a fair process if there is a real, rather than a theoretical prospect of suitable work in which the person exiting benefit can engage.

The nature and magnitude of multiple disadvantage and deprivation that exists among a substantial proportion of the people in Merthyr Tydfil who have a very low level of skills, and limited (if any) qualifications, together with the limited availability of jobs that command a high enough wage to make work pay, threaten the validity, integrity and applicability of conditionality in this complex context. Though conditionality may be an effective approach for those who are closest to the labour market, it will fail the most disadvantaged and marginalised members of society. This is particularly so for those people with health conditions or disabilities who cannot meet the increasingly complex demands and obligations of

participation in the contemporary labour market. Government, society, and the benefits system must make due allowance and provide the right sort of additional help and support for the deprived, disadvantaged and socially excluded. Mutual obligations must work both ways: the ones on society and Government are to provide the social structures, support and incentives required before imposing conditionality on already disadvantaged and deprived benefit recipients. These structures and support systems must first be put in place before conditionality can be justified and effective.

To increase economic activity in Merthyr Tydfil, we need to get to the root of the problem, and engender cultural change, improve health, education, training, and employment prospects, rather than rights being conditional on meeting certain responsibilities. The area is undergoing a much needed regeneration process, but more investment is needed, and the recovery of this area will take some time. Needs must be identified and met first: encouraging and supporting people in gaining skills and building confidence, equipping them to find suitable work which pays.

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